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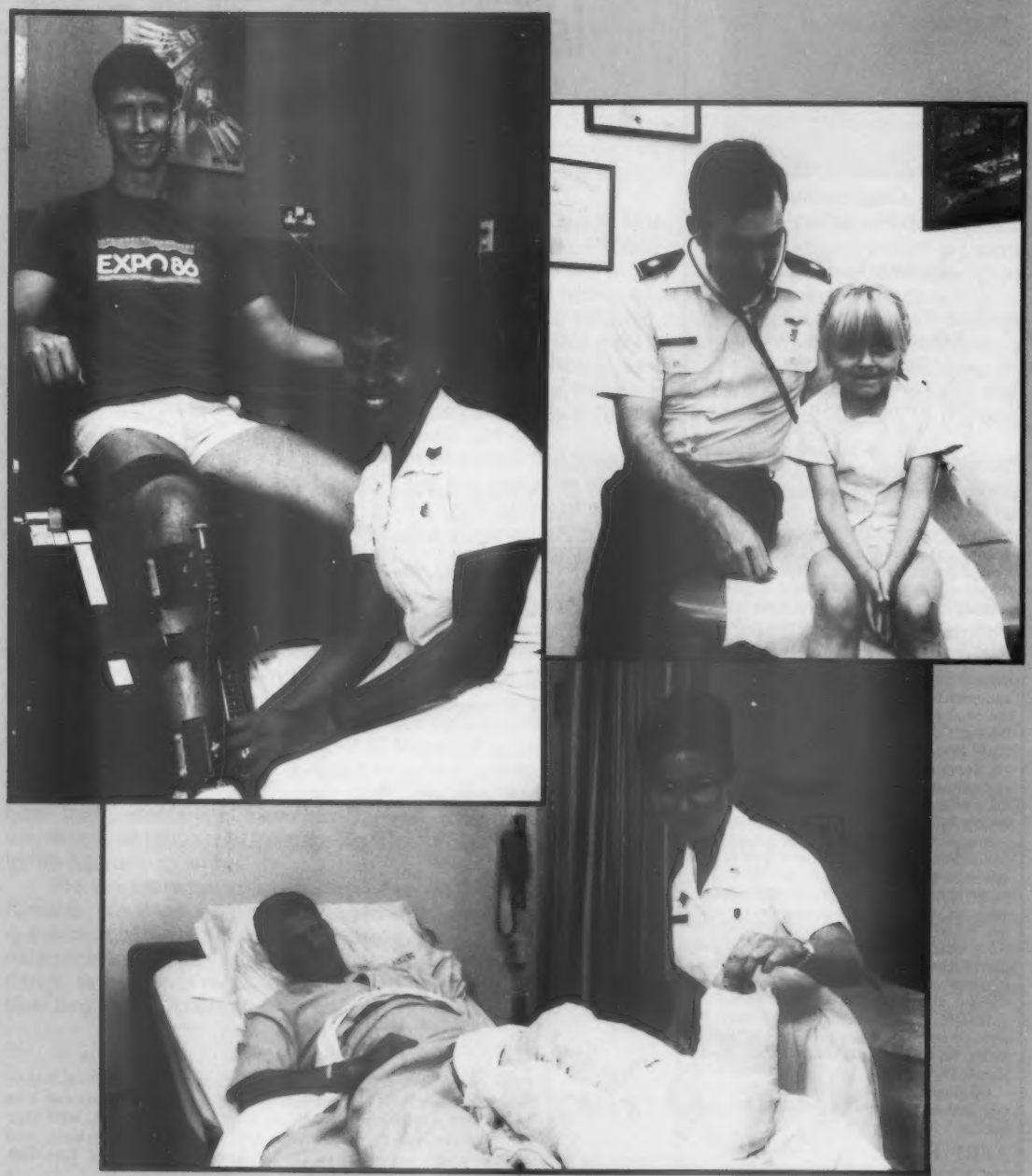

Patient care begins with caring (see lead story)

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Front cover: Providers caring for patients at the 20th Tactical Fighter Wing Hospital, RAF Upper Heyford, United Kingdom (clockwise from top left): Physical therapy technician, SSgt. Maureen Sawyer, with SSgt. Darrell Kent; family practitioner, Maj. (Dr.) William Sykora, with Amber Fugate; and nurse, 1st Lt. LeeAnne Lamer, with Sgt. Kim Gall.

Message from the Surgeon General

There's a lot of discussion these days about Total Quality Management, and whether it is applicable to the Air Force Medical Service. Some people say, "It may work in a product-oriented organization, but we're a service-oriented organization." Well, I'm here to tell you that we do have a "product"—happy, healthy patients. And what they want and deserve is quality, compassionate care.

Our greatest emphasis for the 90s has got to be on focusing our mission exactly where it belongs: on the patient. The patient must come first, despite our necessary preoccupation with regulations, resources, and requirements. If we take the time to care for, rather than treat, the patient, I believe the rest will follow—we will have cost-effective, quality care that exceeds the standards. The "quality first" approach of TQM is just plain common sense. It's really a "back to the basics" philosophy of management.

Having "a good bedside manner" is more important than ever today. In this era of high-tech medicine, outpatient surgery, HMOs, and PPOs, the patient is often left feeling rushed, confused and insignificant. The fact is, a patient's perception of the quality of care received has more to do with his or her personal interaction with medical staff than the technical aspects of care. This is to our advantage because, while the costs of new equipment or facility upgrades are high, compassion is free—and we have it in unlimited quantities.

Getting back to the basics means communicating with our patients. We need to be there for them—take the time to listen to what they say, explain things thoroughly, and make sure they understand. We're not doing our jobs unless we provide emotional as well as physical healing. As we communicate, we should do better at convincing our patients that they have some responsibility for their own health, not only in following instructions for treatment, but in pursuing a healthy lifestyle.

Another basic rule is to follow up. Our responsibility for our patients does not end when they go out the door. From a medical perspective, following up with a patient is an important part of our job. But it also brings in an enormous dividend in patient satisfaction, and at a small price to our time.

Yes, effective communication does take time, and time is at a premium. I understand that. But consider that patients who leave our facilities, reassured and confident about their treatment, fully understanding their responsibilities, are happier, healthier patients. Ultimately, they will require less of our time in the future.

We are an organization of more than 50,000, yet to many of our patients, we are their small-town hospital. We know them and understand their needs better than anyone else. This sense of community is the core of the Air Force way of life, and we are among its primary custodians. Changing trends and rising costs in health care mean that, as an organization, we must find new and better ways of doing things. But, as individuals, we need to remember the old values. In the words of F. W. Peabody, "Patient care begins with caring for the patient."

Monte B. Miller

MONTE B. MILLER
Lieutenant General, USAF, MC
Surgeon General

Patient Care Begins with Caring

Maj. Gary R. Uremovich, BSC

Quality medical care and low liability risks have been shown to have a common denominator—good communication between patients and their providers (1). Investigators into the therapeutic process consider the doctor-patient relationship to be the cornerstone of medical care (2). The importance of effective interpersonal skills upon this relationship is critical.

The empirical focus in medical science has led to remarkable advances in medical technology, quality assurance protocols, and health management. These developments have, in the minds of some clinicians, eclipsed a vital dimension in caring for patients—the interpersonal relationship between provider and patient. High-tech modalities are inadvertently seen as more important than the less tangible area of communication skills (3). Seemingly, treatment of disease has replaced caring for patients!

Encourage Patient Participation

This impersonal, technocratic, and disease-centered approach fails to recognize the patient's active role in medical care. Diagnosis and treatment is viewed as a scientific process that has little to do with the soft methods of counseling or psychotherapy. Nothing could be further from the truth! The medical encounter contains most of the elements found in psychotherapy such as support, ventilation and clarification (4). Effective treatment of patients hinges on strong interpersonal skills.

Communication skills should not be considered secondary to the more technical aspects of medicine. The patient is an active agent in the medical process. His or her perceptions can have a dramatic effect on treatment outcome. In fact, motivating or engaging patients in their own care is crucial to the treatment's success. Studies have shown dramatic clinical benefits when communication skills are effectively used (5):

- Increased patient satisfaction
- Genuinely informed consent
- Increased patient compliance
- Quicker recovery from illness
- Increased patient knowledge and recall

Each of these areas are critical to patient care. Skill in maintaining open and positive communication between the provider and patient is vital in treatment outcome. Any hindrances to this process must be explored and resolved before medical treatment can be delivered adequately (6).

Save Time through Effective Communication

For most providers, the expression "good bedside manners" implies the luxury of time and personal resources. Open-ended questions and the ramblings of patients with multiple complaints is permissible in the academic setting, but not during a busy sick-call or in the emergency room. However, research demonstrates that good communication skills actually use less time (7)—less time, but increased compliance and patient satisfaction! Conversely, poor communication skills,

Sgt. Tim Chislea, physical therapy technician at the 20th Tactical Fighter Wing Hospital, RAF Upper Heyford, United Kingdom, gives care to Sgt. Lamont Downs.

Capt. Bob Wishtischin, physical therapist at the 20th Fighter Wing Hospital, performs an ultrasound on Sgt. Harold Atwell.

despite longer interaction time have been shown to inevitably produce dissatisfied patients (7). It is because of time constraints that we must focus on more effective patient-centered communication.

Show a Caring Attitude

Appropriate treatment frequently can be perceived as inadequate by patients because of faulty skills in communicating by the provider. A mother related how an emergency room physician had seen her child and diagnosed an ear infection. When the mother asked the provider about possible hearing problems as a result of the illness, she was curtly told "just give the medicine." Her question and concerns were left unanswered. The doctor had made the right diagnosis, prescribed the correct medication, and scheduled timely follow-up. However, the mother had been alienated by what she thought was an uncaring attitude. What happens if that child develops a suppurative complication of that ear infection (i.e., mastoiditis or meningitis)? What happens when that patient sees the provider again for a different complaint? Will the mother's negative experience carry over into another encounter?

It is important for every provider to be aware of how his or her behavior can influence the patient's perception of medical care. Even unspoken attitudes held by medical personnel can adversely affect their interaction with patients. Communication is a complicated process that involves both verbal and non-verbal interaction—thoughts, feelings and biases are influential in how effectively we respond to others. The great diagnostician, F. W. Peabody, said, "Patient care begins with caring for the patient" (8).

Patients bring their personal fears and expectations to the doctor and not just a set of symptom complexes (7). The most competent clinician can fail to render adequate treatment in the view of the patient if compassion is thought to be lacking. Someone has said, "Before someone cares how much you know, they want to know how much you care." Sadly, the medical profession can often be seen by outsiders as impersonal and unconcerned. Cool, calculating technocrats are inadequate replacements for competent, compassionate and concerned clinicians.

Take Time to Listen

The medical profession has a bias concerning patient involvement in medical care. The "good" patient is viewed as passive, non-questioning and non-challenging to the delivery of health care. This patronizing attitude is inappropriate (5) and damaging to adequate patient care. The medical process must be patient-centered. The patient brings questions that must be answered, fears that should be quelled, and personal health goals that demand clarification. The objective for the provider of care is not merely to make the diagnosis and treat. That is important—but the job of caring for patients is much more involved than that! The provider has not discharged his medical obligation until the patient is truly "cared for."

The practitioner can sabotage meeting the patient's needs within the first few moments of the clinical interview. The doctor's own motivations and perspectives can obscure effectively discovering the purpose of a patient seeking help (5). In a study of 74 outpatient visits, the opening statement to the provider, made by patients explaining the purpose of their visit, was completed by only 23 percent before the provider interrupted (2). The result was that important information was never allowed to be developed by the patient. Preconceived ideas, biased

attitudes, and emotional distortions must be recognized and compensated for (2). Every contact with a patient should be new and fresh with the doctor remaining open and receptive (7). When this is not done, big mistakes can be made!

In 20 years of observing patient-provider interaction, I have witnessed incredible examples of distorted communication: the superb surgical skills of a top-notch surgeon maligned because of his insensitivity to patients and staff; an infected surgical wound considered to be gross negligence by a patient because of inadequate preoperative informed consent—the patient simply did not realize that sometimes infections develop despite appropriate surgical and aseptic techniques. I could go on. But suffice it to say that bad communication is easy to recognize by its catastrophic result.

Guidelines for Successful Communication

Providing medical service is a privilege and a responsibility. The most important factor is to really care for our patients. Effective caring can be simply translated by two attributes—compassion and concern—and the skill to communicate them. The following guidelines can help us to keep track with patient-provider interaction and avoid some of the pitfalls noted earlier.

Realize how important communication is in the clinical setting. Become a student of how you communicate with staff and patients. Then improve your skills! Overall, communication is composed of 7 percent verbal content, 38 percent vocal tone, and 55 percent body language (9). Listen to the patient carefully before talking. Then watch "how" you say and not just "what" you say. Take advantage of opportunities to sharpen specific communication skills such as "active" listening.

Do an attitude check. What you think affects your relationships with others. Negative thoughts about patients or other staff members will be reflected in how you communicate. Thinking of patients as "crocks," "wimps," or "abusers" of medical care can be dangerous. Even "crocks" get sick! Maintain a positive and open attitude with every patient.

Resist a common tendency to manipulate the patient into your agenda. Watch to see if you interrupt the patient as he or she unfolds the purpose for seeking care. Don't forget—in the study cited previously, more than 75 percent of the time patients were interrupted before finishing the opening remark. Listen carefully to verbal and non-verbal clues as to the nature of the patient's visit. Encourage feedback to ensure you have actually met the needs of the patient.

Learn to enjoy interacting with staff and patients. Positive communication is enjoyable. Look for opportunities to encourage others—and then do it! A positive approach to patient care is a tremendous asset and can be infectious. Positive communication with staff and patients is a morale booster.

Conclusion

To care for our patients, we don't need the wisdom of Marcus Welby, the intensity of Dr. Kildare, or the intelligence of Ben Casey. Those super-docs are the product of celluloid from Hollywood. Without question, competency in medical technology and diagnostics is important. However, what is urgently needed is a heightened awareness of how we can more effectively communicate with patients.

Communicating in health care delivery must begin with the provider first "caring for the patient" and, second, demonstrating this by caring to communicate effectively. Effective communication between providers and patients is the cornerstone of medical treatment.

Maj. Gary R. Uremovich is a physician assistant with the 20th Tactical Fighter Wing Hospital at RAF Upper Heyford, United Kingdom.

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Productivity: It's Not a Dirty Word

Col. James M. Jacobson, MC
Col. John A. Watters Jr., MC

One of the results of the continuing revolution in medical care has been a shift of patient care to the ambulatory setting, causing burgeoning demand in the outpatient clinic.

Paradoxically, Air Force workload accounting methods, based on inpatient admissions and outpatient encounters, document an apparent fall in measured productivity. This exists in spite of an increase in Air Force practitioners and increased spending. No wonder that the military health care system is scrutinizing productivity in response to pressure to provide efficient, high quality care.

Quantity As A Component Of Quality

Patients who express dissatisfaction about health care delivery in the ambulatory care setting provide further incentive for improvement. In fact, nearly 80 percent of all patient complaints originate there. Most describe an inability to receive care in a convenient and timely manner, and relate directly to productivity. A leadership strategy that embodies quality management techniques can improve productivity without additional resources.

There is no single, satisfactory way to define medical care. It has been measured in terms of patient visits, disease episodes, cost, time, cure rates, sick days per 1000 population, and well-being (1-3). Each of these measures may be valid; however, we can not overlook the fact that any health care system exists to help people feel better. Effective day-to-day management of ambulatory clinics requires attention not only to the quality of care delivered, but the impact when care is not delivered. Quantity of care delivered should be one measure of quality.

Components of a health care system include practitioners, facilities, supporting staff, patients and leadership. In the ideal situation, properly educated and motivated practitioners care for patients in a facility with enough, but not too much, space and equipment, assisted by adequate staff to provide efficient, compassionate, quality care. While some components may not be in the direct control of the Medical Treatment Facility (MTF) commander, leadership and effective management techniques are. The commander must locate or develop effective managers, implement programs that promote the ideal in medical care, and execute strategies which improve the quality and quantity of care (4).

Provider Specific Goals

Mere mention of the word productivity arouses instant anger and hostility in most clinically active Air Force practitioners. Ill-defined and variably monitored standards, accompanied by poorly executed programs have spawned derogatory productivity terms such as 'bean count' or 'body count.' The Provider Requirements Integrated Speciality Model (PRISM), developed to predict staffing requirements under optimal circumstances, has been turned upside down and used as a productivity standard without consideration of its original purpose or limitations. Many practitioners infer that executive management values meaningless numbers more than compassionate and quality care. These practitioners therefore resist efforts to improve productivity. They fear that increasing the quantity of encounters will decrease the quality of the individual encounter, for which they are ethically and legally liable.

Involving each practitioner in the definition of expectations for his practice has several advantages. It accounts for variations among MTF resources while allowing for individual capabilities and responsibilities. Further, military medicine demands attention to a number of responsibilities not always present in a civilian practice—readiness training, exercises, teaching and supervision. These may require from 1 to 99 percent of the time that a given practitioner has available for outpatient care.

The individual who influences the expectations of his own performance is more likely to "buy into" the process—he will be more likely to accept the goal and try to reach it while meeting personal standards of quality and compassionate care.

The supervisor who sets reasonable provider specific goals (PSGs) after consultation with a practitioner has taken the single most important step to influence productivity. Expectations are clarified, not only for workload measures, but for all aspects of duty performance. The supervisor has thus accomplished the first of three principles of good management—goal setting, praising and reprimanding (5,6).

Clarifying expectations may seem elementary; however, physician supervisors frequently are hesitant to clarify goals when supervising other practitioners. They assume the practitioner understands how to define his tasks and responsibilities. However, most practitioners allocate time for a medical encounter

Steps to increase productivity and improve quality

1. Involve the practitioner in goal setting.
2. Set goals for outpatient encounters.
3. Institute meaningful measures of productivity.
   a. Provider Specific Goals (PSGs).
   b. Clinical Unit Goals.
4. Assure that actual work is reported.
5. Provide regular feedback to practitioner and supervisor.
6. Provide tangible rewards.

Table 1

based on the severity of the medical disease rather than the number of patients desiring medical treatment. This emphasizes quality of an individual encounter rather than a number of encounters. Good supervision and goal setting helps the practitioner balance quality and quantity.

Allowing the supervisor to set specific outpatient encounter goals contrasts with the traditional approach that the director of hospital services is responsible for all individual appointment schedules. This causes supervisors to abrogate responsibility for defining expectations of the director. Worse, it undermines the supervisor's authority, discourages leadership development, and creates a "them versus us" attitude.

Clinical Unit Goals

Clinical unit goals are the sum of the goals for individual providers within the unit. While the clinic unit supervisor is responsible for setting PSGs for practitioners, the director of hospital services should determine the appropriateness of clinical unit goals.

The Utilization Review Committee at most Air Force MTFs focuses on use of the inpatient facility. If productivity in the outpatient setting is important, then we must develop measures to describe that to clinical unit supervisors.

Most MTFs report only total outpatient visits per provider per month. Though this measure may be useful to Air Staff or major commands, it is not meaningful to practitioners and providers because it is not individualized for specific skills. Further, it does not consider all that is expected of the provider. For example, whether Provider A who saw 425 patients in one month, or Provider B who saw 350, was most successful depends on practice expectations; if Provider B was expected to see 250 encounters, then he exceeded expectations.

At our MTF, we amended the productivity report to include both the supervisor's expectation of the number of outpatient encounters for the month, a PSG, and the percent of the goal achieved. Percent of success equals the number of encounters times 100 with that sum divided by the PSG figure. This method of measuring success is independent of other time consuming responsibilities and allows more meaningful comparison of individual providers within the clinical unit. Importantly, every provider has a reasonable opportunity to be 100 percent successful in achieving the PSG. When actual clinic encounters (the sum of individual provider encounters) are divided by the clinical unit goals (the sum of PSGs) then unit success is measured.

Initial use of PSGs and clinical unit goals will meet moderate resistance because both supervisors and providers fear that goals will be used as a rationale to inappropriately punish individual providers. The wise director of hospital services should emphasize clinical unit goals rather than PSGs. Executive management review of PSGs is usually inappropriate. Interaction with the individual provider is the responsibility of the immediate supervisor. This approach allows the clinic chief or chairman flexibility in management and goal setting, but maintains his accountability for the overall clinical unit goals.

Accurate Reporting

Decreases in productivity are caused by underreporting. For example, at one MTF, low reporting was shown to account for 10 percent in obstetrics and gynecology, 30 percent in internal medicine, and 5 percent for surgical clinics. Underreporting is partly due to lack of practitioner incentive, which stems from the perception that measured workload, though important for long term manning, has little immediate impact on the individual practitioner or clinical unit. Most practitioners and clinic support personnel are surprisingly unaware of what is a reportable visit.

Successful workload reporting requires, careful examination of procedures for capturing workload, limited dependence on the provider for clerical tasks, and education of all clinic personnel in reporting procedures. PSGs and clinical unit goals promote teamwork because both individual and clinical unit success are dependent on efficient reporting. Every employee becomes an important contributor.

Effective Feedback

Feedback about performance should be frequent, informal, largely self-evaluative, non-judgmental, accurate and informative. At a minimum, every two to three months the supervisor should discuss previous success at achieving the PSG and completing other responsibilities with each practitioner. Discussion should usually begin with the practitioner's self-assessment of performance, a technique which involves the practitioner in the assessment process and avoids one-way, supervisory judgment. Accuracy of the report is crucial, because the provider's success or failure depends on it. Feedback should help improve performance rather than communicate a final evaluation.

Recognition and Rewards

Sustained superior performance is more likely in a setting where recognition is given, so rewards for outpatient care deserve emphasis. Most practitioners want to work hard to provide quality care because they derive satisfaction from healing and providing comfort. Nonetheless, they may derive less satisfaction from outpatient than inpatient encounters because of differences in time available to develop rapport, availability of support services, or intensity of the underlying disease process. Furthermore, concern only for providing quality care may not promote the organizational goal to increase the quantity of care. Standard rewards such as salary, prestige, rank or officer promotion recommendation are usually unrelated to the number of patients seen.

Supervisors in outpatient clinics frequently should provide simple rewards such as: feedback, self-determinism in choosing a clinic schedule, recognition within the unit, preferential treatment in choosing administrative activities, priority for special events, or priority for permissive temporary duty.

The commander or director of hospital services should reward clinical units based on exemplary performance, including performance for quantity of care delivered. Some simple rewards we have used at Wilford Hall USAF Medical Center include: 1) A pizza lunch for the entire clinical unit staff, hosted by the SGH staff. 2) A report by the clinic chief to inform the Medical Staff Executive Committee, on how we achieved success. 3) Additional authority to purchase equipment given to the clinic chief. 4) An additional dollar amount is added to the next annual clinic continuing medical educational (CME) budget, for every practitioner assigned to the clinical unit.

Other ideas include gilt-edged calling cards for providers from successful clinical units (Peters), recognition at commanders call, lunch with the commander or director of hospital services, an achievement medal for customer-oriented clinical units, or a rotating plaque. The key issue is not the type of reward, but that rewards exist at all.

Reprimands are far less desirable than a positive reward system and should be employed rarely. A formal reprimand is not appropriate without previous, consistent, accurate feedback and definition of expectations (5).

Conclusion

Improving the productivity of a large organization is challenging. It requires the talents of many people. It takes time, resources, and an effective leadership strategy. The strategy described emphasizes quality and quantity of care, allows some self-determination, recognizes the value of both practitioner and clinical unit, and recommends tangible rewards.

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"Even if you're on the right track, you'll get run over if you just sit there."

Will Rogers

Reflections on Health Professions Recruiting

The Challenges and Rewards

2nd Lt. Kimberly S. Coleman

Each day across America, a select group of Nurse, Biomedical Sciences and Medical Service Corps officers take on one of the toughest jobs in the Air Force Medical Service—health professions recruiting. The 71 medical officers assigned to the recruiting squadrons and groups must ensure that only the highest quality health professionals are recruited into the Air Force. During fiscal year 1989, they brought 1,564 new medical officers into the Air Force.

Prescriptions for Success

What does it take to be a health professions recruiting officer? Some say it's enthusiasm and the desire to talk with people. Perhaps it's strong dedication to the Air Force mission. Whatever the reason, it's clear that some of the most dynamic Air Force officers are chosen to be a part of the Air Force recruiting team. And because of the constantly changing environment, family support is essential.

"Being in recruiting takes a work-hard ethic, a positive attitude and enthusiasm," said Maj. Bethany L.H. Rice, Nurse Recruiting Office, 3564th USAF Recruiting Squadron, in Sacramento, Calif.

Maj. Arthur J. Nilsen, nurse program manager of the 3511th USAF Recruiting Squadron, in Pittsburgh, agrees. "You must love the Air Force, be enthusiastic and be totally dedicated to the mission—duty hours are irrelevant," he said. "A 60-hour work week is not unusual."

This type of work schedule requires not only personal commitment, but a great deal of support from family and friends as well. "I have one son who is six years old now," said Major Rice. "He has benefited greatly from being an Air Force child. As a single parent I have developed a strong support group through friends who help out when it comes to child care. But then again, I have always found the Air Force family there to help," she explained.

"Recruiting can be tough because of working late or TDYs. There are no set hours," said Capt. Lamar Odom, medical recruiting officer at the 3552nd USAF Recruiting Squadron, near Wright-Patterson AFB, Ohio. "I'm married and have two sons, so time management is very important. Fortunately, I have a very supportive family."

Making a Difference

Under these circumstances, recruiting can be difficult and stressful. What is it about these professionals that motivates them to achieve? The answer: For successful recruiting officers, there is a feeling of pride and accomplishment in putting quality medical personnel in the Air Force.

"I volunteered for Recruiting Service to have the opportunity to make a direct impact on the quality of medical care we receive in the Air Force and to work in a position that allows me to put my success or failure in quantifiable terms," said Captain Odom, who is a hospital administrator by profession. "In recruiting, you see your contributions directly," he stated.

Maj. Joseph Durio, a physician's assistant who is the medical recruiting officer with the 3541st USAF Recruiting Squadron in San Antonio, Texas, shares Captain Odom's perspective. "It's most rewarding to see the caliber of doctors and the quality of BSCs and dentists in the Air Force, and to know that my team had something to do with it," he said. "In two years, I will be working with these people. I hand-picked them and I would work with any one of them at any time."

Esprit and Teamwork

Being a part of the recruiting team requires sacrifice, but it also includes intangible rewards. There's a great sense of esprit de corps and teamwork. With the support of some highly motivated non-commissioned officers, many health professions recruiting officers get off to a good start.

"In recruiting you become very attached to your unit," said Major Durio. "Your squadron is more cohesive than in the hospital. As a result of being in recruiting, I've had a good overview of the entire Air Force. I've also improved my leadership and management skills.

"On my first day, I was at ease because of the quality senior NCO who directed the efforts of the team. I was able to adapt much easier," he added.

Captain Odom, whose squadron is now rated number one in the 3505th USAF Recruiting Group, said he also enjoys "working with the most motivated

Nursing school graduate, Carolena Banero, is commissioned into the Air Force Nurse Corps as a second lieutenant.

and innovative NCOs in the Air Force. They have an insatiable desire to succeed, which makes being a recruiting officer easier."

Integrity and Experience

Most civilian health professionals and Air Force people have little contact with recruiters. As a result, misunderstandings and stereotypes are not uncommon.

"Many people perceive that recruiters lie. I believe in telling people everything," said Captain Wright. "There's no sense in not telling the truth. I want people to be aware of what's ahead of them. They often come back later and tell us they are thankful we were up front and open with them."

"I don't consider myself a salesman, though many people think you have to be," said Major Durio. "I'm a representative of the Air Force who is showing another option, another alternative for physicians. As a team, we tell the positive and negative of everything."

The most successful recruiters believe in what they're "selling"—the Air Force—and that enthusiasm is often transmitted to the potential recruit. "I knew a lot about the Air Force before I joined Recruiting Service. I can talk about the opportunities because I've experienced all of them," said Major Nilsen.

Captain Wright's enthusiasm began with her attraction to flight medicine. "The Air Force is the only service with flight nurses, which is a real selling point," she said. "I've always wanted to be a nurse, and when I finally decided, I knew I would be an Air Force nurse."

For More Information

The views of these officers strongly suggest that in Air Force recruiting, dedication, teamwork, and—most importantly—a love for the Air Force are keys to success. These motivated and highly creative officers encourage others to see the benefits and challenges of a career in the Air Force Medical Service.

If you think you'd be interested in the challenges afforded by a tour in health professions recruiting, contact your utilization officer at the Air Force Military Personnel Center or the Health Professions Directorate at Air Force Recruiting Service (HQ USAFRS/RSH, Randolph AFB, TX 78150-5421, TELEPHONE: 1-(800) 531-5980). Or contact your closest Air Force Health Professions Recruiter!

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Digest Interview

Maj. Gen. (Dr.) Edgar R. Anderson Jr.

On May 11, 1990, the *"Digest"* interviewed Maj. Gen. Edgar R. Anderson Jr., as he departed his position as command surgeon, Strategic Air Command, for his new assignment as commander, Wilford Hall USAF Medical Center, Lackland AFB, Texas. Highlights from the interview, including his views on SAC medicine today, leadership, the quality and future of Air Force medicine, and other areas are presented here as the first in a series of interviews with AFMS leaders.

Digest: "General Anderson, as you prepare to leave Strategic Air Command for an assignment at Wilford Hall, how would you assess the state of medical service at SAC?"

General Anderson: "Quality unequaled, quantity inadequate—just those four words. By any measure of merit, the quality of the SAC medical system is absolutely unparalleled. We have really had a dramatic increase in the number of Health Services Management Inspection ratings above satisfactory and a decrease in the number of ratings below satisfactory. We are very proud of our success with the HSMI inspectors, and I'm very confident in the quality of the medical care offered in SAC. Clearly, we don't have enough health care personnel, and we need a lot more, particularly in primary care. But we have our fair share."

Digest: "Are there possibilities of getting more?"

General Anderson: "Well, we're working at it. That's priority one: retention of the ones we have and recruitment of more."

Digest: "Retention is a problem in some specialties. What can be done to resolve it?"

General Anderson: "We have to get all of our people to buy into the Air Force mission. We must make them understand their part in the mission at the unit level, whether that mission is flying airplanes or minding missiles or whatever. We've got to educate them about what we're really here for and how critical their part is in that. Then I really believe we will retain the right ones—those who have a feeling about the Air Force and are motivated in the right way. The people who really love the Air Force and believe in what we're doing will stay in as long as we can compensate them in a reasonable way."

Digest: "General Chain, the SAC commander in chief, said recently that SAC would be forced 'to do less with less.' How will this affect Air Force health care?"

General Anderson: "Fortunately, in the medical business we're not going to be forced to do less with less in the future. The chief of staff and the CINCs of the major commands have decided to "robust" the Medical Service with a 2,000 manpower add, with the CHAMPUS add and several other things. They have provided some money to go out and locally contract for support personnel. So we're in a unique position in the Air Force Medical Service of having to do more with more.

"My position is that the line of the Air Force has made a conscious decision to enhance the Medical Service despite declining force structure and line resources. So we have got to pay that investment back by providing more with more. Now, we think those adds are going to give us some efficiencies that will return more than a one-for-one investment. We have been resources-poor in the support and facilities areas, and we hope that by adding these resources, we're going to return some efficiency to the operation."

Digest: "Did you accomplish all of your goals as SAC surgeon? If not, what remains to be done?"

General Anderson: "Well, of course not. I'm not sure that anyone ever does. The one that I'm most frustrated about is the quality of our medical facilities. We have a program to upgrade them called

'SHARP'—the SAC Hospital Alteration and Restoration Program—that we are very proud of. We have come a long way. But they're not 1990 standard yet, and until they're state-of-the-art, or as good as we can make them, I really won't be satisfied. But in most of the other areas, in terms of improving quality of care and the caliber of people who are running the SAC medical service at the hospital commander level, I feel very positive and confident with the state that I'm leaving SAC in."

Digest: "Are there any special factors that distinguish SAC medical assignments from others in the Air Force?"

General Anderson: "Sure, I think there are many. They're all mission-related—related to the nuclear mission. It causes us to focus heavily on the PRP (Personnel Reliability Program), for example. We spend a lot of time and energy on the PRP; much more than any other non-nuclear command. Nuclear alert, missile medicine is a unique attribute of the SAC medical service.

"We also have a flying mission none of the other commands have. For example, we have the only high flier program, with an accent on altitude physiology—our chambers have to be equipped with hyperbaric capability. We have to have that capability in certain places to be able to treat bends and problems that really don't occur in most of the other air forces that operate at lower altitudes.

"We have the only tanker mission; we have a mission that requires tremendous endurance; and of course we have the only bomber mission. All of those put a different slant on the practice of medicine. I would tell you as an aside as I leave SAC, it has been a tremendous educational opportunity for me. I kind of grew up in the tactical air forces, around fighter aviation and all, and this has really been an enlightening experience for me."

Digest: "SAC has been a leader in the area of health promotion. What role will health promotion play in the Air Force in the future?"

General Anderson: "You should know that health promotion—or 'wellness'—is General Chain's program, and I'm just the action officer! I fully support it and live it, and it has paid handsome dividends in SAC. We all know that it's a lot cheaper to keep people out of the hospital than to put them in. In an era of declining manpower resources, the more we can keep people on the job and out of the hospital, the better off we are.

"Although it's difficult to quantify, physical and emotional fitness and a sense of well-being really contribute in great measure to combat effectiveness and job performance. There are a lot of studies that show that a physical fitness program that involves aerobic exercises three periods a week increases your productivity by 20 percent. So that's a net gain—an asset—not a liability. It doesn't take away from the job, it adds to it. We are also very aggressive in SAC about nonsmoking and cholesterol reduction."

Digest: "Leaving SAC for Wilford Hall represents quite a change. Is there a philosophy of leadership that you bring to each new job?"

General Anderson: "Well, there certainly is. I talk about leadership and officership a lot. I think that the core values of integrity, loyalty and courage are paramount, regardless of whatever job you have in the Air Force. I also think that commitment is the glue that holds all of those things together. I certainly expect both the staff and graduates at Wilford Hall to be first and foremost top quality Air Force officers whose specialty is first-class medical care—I really believe that quality officership and quality care are mutually supportive. And when they leave there, I expect them to be well-rounded Air Force officers, able to address Air Force issues like nuclear deterrence, why we need the B-2, and arms control."

Digest: "What do you perceive to be your greatest challenge at Wilford Hall?"

General Anderson: "Well, that's an easy one: to improve on the already near-outstanding state that the hospital is in. That is going to be a difficult task, but I really believe that no institution is static. They all either get better, or they get worse. I've had opportunities in my career to take over wobbly organizations, and those are always easy to fix. But when you take over one as good as Wilford Hall and try to make it better, it's really a tough challenge. I've had those opportunities also."

Digest: "Wilford Hall is the Air Force's largest medical education center. Do you think we're getting our money's worth out of the funds used for medical education?"

General Anderson: "I certainly do. It's absolutely essential. It's the lifeblood of our health

care system—the young physicians who come out of the training programs at Wilford Hall, Keesler, Wright-Patterson, and Travis, as well as the family practice centers like Malcolm Grow at Andrews. By all criteria, they are the crème de la crème of American medicine. The Health Professions Scholarship Program is superb. We just get the best that America has to offer; we send them to the best medical schools; and then we educate them at the military residency programs where we can. Their board scores exceed the national average in every major specialty.

"I tell you, I won't let anybody talk about the quality of Air Force medicine in a negative way. I am very aggressive in responding to questions that demean the quality of Air Force medicine because they are totally unfounded. Whenever I talk to groups of hospital commanders, I tell them all the same thing: 'That is your medical service, so don't you let anyone talk about it in a demeaning way unless they're factually correct, and beware of using isolated events to make generalizations.' I will be happy to supply you with a litany of arguments—substantial arguments—to refute any anecdotal assaults on Air Force medicine. I really mean that."

Digest: "Along those lines, General Anderson, what are your thoughts on total quality management and total quality care?"

General Anderson: "I've got to tell you that I am really intrigued by the TQM business, and it seems to me to be the first totally sensible management scheme I've ever heard of, since it seems to focus on the product and really get feedback from the patients. I will tell you right now that I don't know everything that I intend to know or need to know about TQM, but I am certainly attracted to it. When I go down to Wilford Hall, we're going to look at TQM, and where it supports what we're doing there, we're going to use it. I think there are some applicabilities of TQM to the Air Force quality assurance program. In fact, they are probably mutually supportive.

"My down-the-road goal for Wilford Hall is to work hard my first six months to prepare for an HSMI in January. Beyond that, I think there are some things we really need to do in terms of simplifying, streamlining and standardizing the quality assurance program. When the residents graduate from down there, they've got to practice the Air Force brand of medicine, and quality assurance is part and parcel of that. Quality's got to be a part of the Air Force medical training culture, so that when people leave Wilford Hall, they accept it as a way of life. I do think we can make it better. We can streamline and standardize it. And I think in some way TQM will fit in with that. But that's project number two. Project number one is taking that medical center through the HSMI in January and making it the best it can be."

Digest: "Wilford Hall was a participant in Operation Just Cause last December and is credited with doing a tremendous job. What is your perspective?"

General Anderson: Well, I think they did a marvelous job. And you know, there's nothing that builds unit cohesion and esprit de corps like this kind of event where we do what we are really in the business of doing—supporting the operational mission of the American forces. That's why we're all in the Air Force; that's what it's all about. It gives me goose bumps just talking about it! I have tremendous faith in the ability and commitment of the Air Force Medical Service to meet a test like that whenever and wherever it occurs."

Digest: "General Anderson, what is your vision of tomorrow's Medical Service?"

General Anderson: "I think we will continue to have a medical system that is unparalleled in quality. We have got to address the retention and recruitment and quantity issues. We are certainly being given an opportunity by the line of the Air Force for whom we work and to whom we are responsible. They are making a substantial investment in the Air Force Medical Service and we have to give them a return on that investment."

Digest: "Are there any 'words of wisdom' you would particularly like to share with our readers before we conclude this interview?"

General Anderson: "There are a few thoughts that I would like to leave. First, do the very best you can at every job that you're given. Leave every place better than you found it. Second, do what the Air Force asks you to do when they ask you to do it. Then the Air Force will take care of the rest.

"Third, don't try to be too doggone clever—this is more a liability than an asset. What I mean is, there are people who are constantly trying to beat the system out of something. There is a formal and organized way to do things, and you need to help the system. Over and over, we see people running medical operations who just seem to think they can cleverly outwit the system and get more than their fair share—that is just suicide.

"Fourth, you need to know and work your boss' priorities. And finally, believe that the more you do for the Air Force, the more the Air Force does for you. The Air Force is very cognizant of people who are really on the team and will go to no ends to help them."

Digest: "Thank you, General Anderson."

Volunteers carry orphans aboard C-141 at Hickam AFB, Hawaii, in the spring of 1975.

Operation Babylift

Brig. Gen. Michael J. Torma, MC
George M. Watson Jr., Ph.D.

In the spring of 1975, the Vietnam war was drawing to a close. Both Saigon, then the capital of South Vietnam, and Phnom Pen, the Cambodian capital, were severely beleaguered by communist forces. Convinced that savage fighting lay ahead, President Gerald R. Ford announced that America would evacuate more than 2,000 South Vietnamese and Cambodian orphans. These children had all been identified for adoption by sponsors in the United States, Europe and neighboring countries such as Thailand.

Evacuation Operation

The aeromedical effort took place from April 4 to May 6, 1975, and became known as ''Operation Babylift.'' The endeavor involved C-130 (in-country only), C-5 and C-141 aircraft of the Military Airlift Command (MAC), as well as commercial 747s chartered by philanthropists and various humanitarian organizations such as World Vision Relief.

The operation began tragically. Hours after President Ford's announcement, a MAC C-5A—the only time a C-5 was used for ''Babylift''—carrying infants, flight crew and caregivers, took off from Saigon for the Philippines. As the huge transport climbed to cruising altitude, seals at the rear of the fuselage failed. Flight controls were lost, and the cabin rapidly depressurized. The crew tried to return to Saigon's Ton Sun Nhut Air Base, but the crippled aircraft crashed two miles short of the runway. Of the 314 people on board, 138 were killed, including 10 medical attendants.

After this terrible start, the airlift proceeded much more smoothly. The very next day, MAC C-141s shuttled 141 orphans and 137 other evacuees and escorts from Saigon to Clark Air Base in the Philippines, which had specialized pediatric capability. Thus began the first leg of a long journey for the babies.

Normally, ''Babylift'' flights from Saigon to the United States included service stops at Clark; Andersen AFB, Guam; and Hickam AFB, Hawaii. At these sites, the orphans were cared for by medical personnel and family volunteers. They were medically evaluated in preparation for further movement. Those

who were medically unfit to continue were hospitalized at one of the intermediate stops and moved later. Healthy infants were flown to civilian airports at San Francisco, Oakland, Los Angeles or Long Beach, Calif. Alternate military destinations were Los Alamitos Naval Air Station and El Toro Marine Air Station in California, and McChord AFB in Washington. The largest single group included 329 orphans who arrived at Los Angeles International Airport on April 12 aboard a World Airways 747.

A total of 1,794 youngsters were evacuated by MAC from Vietnam and Cambodia to sponsors in the United States. MAC planes brought out 947 orphans in 24 sorties, and MAC-supported commercial carriers moved 945 in four flights. Private, non-MAC carriers brought out an additional 884 orphans.

Results and Lessons Learned

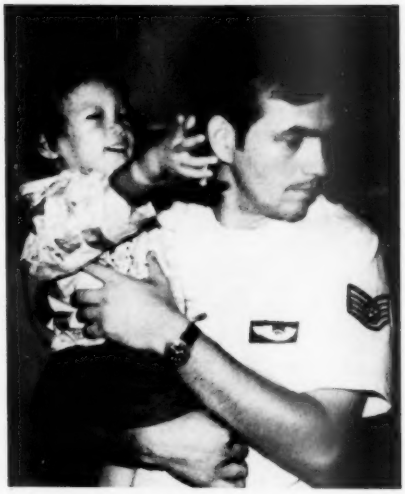
The majority of the 2,678 children transported were under age two. Commonly encountered medical problems included mild to moderate malnutrition, simple dehydration, upper respiratory and ear infections, viral exanthems, skin lesions, and various forms of enteritis. Surgical diseases included cellulitis with abscess, appendicitis, and one small bowel obstruction caused by parasites. Lack of mortality and serious morbidity was attributed to meticulous triage, particularly at the first point of major medical capability.

Logistically, "Babylift" presented the Air Force with the challenge of reconfiguring its casualty-oriented system to meet the unique needs of its tiniest patients. To prevent the spread of communicable disease between children and adults, it was decided that adult patients should not share space on "Babylift" missions.

At each receiving airfield, reassessment of each child's medical status was crucial. Large shelters with adequate lighting, examination tables and equipment were pre-positioned. To expedite rapid patient flow, a flight of 300 patients generally required the following complement of medical professionals: 11 experienced clinicians (led by pediatricians); a minimum of four nurses; and 16 to 20 corpsmen and non-medical volunteers.

Children with questionable health, nutritional or hydrational status were admitted to local hospitals. For infants proceeding on, many were aided by modest antihistamine doses that provided both middle-ear protection and sedation. Flight attendants were informed of any needed in-flight medicines before the children were boarded. In addition to such medications, the aircraft were specially supplied with cardboard bassinets, infant formula, plastic refuse bags, masking tape, disposable diapers, and disposable bottles and nipples.

No in-flight altitude restrictions were imposed, since triage precluded possible "trapped gas" patients being aboard. The children were calmed and reassured. They were given small, frequent feedings adjusted in calories and fluid tonicity. In this manner, abdominal distention, airsickness, and diarrhea were avoided as much as possible. Psychosocial disruption (which, had they not been orphans, would be better prevented by keeping families together) was lessened somewhat by keeping the same non-medical attendants with the children for the entire trip.



Air Force medic carries child during Operation Babylift.

Conclusion

"Operation Babylift" was a humanitarian effort to remove children from danger. The evacuation depended upon close coordination among operational planners, aircrews, medical professionals, and hundreds of volunteers along the way. Their combined actions permitted us to take advantage of a unique opportunity—that of transporting the innocent children of war to safe havens.

Brig. Gen. (Dr.) Michael J. Torma is the command surgeon, Headquarters, Strategic Air Command, Offutt AFB, Neb. George M. Watson Jr. is the chief historian, Office of the Air Force Surgeon General, Bolling AFB, D.C.

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Top: *Air Force doctor at Travis AFB, Calif., meets arriving orphans.* ***Bottom left:*** *Air Force personnel help the children board an aeromedical evacuation flight.* ***Bottom right:*** *A volunteer at Hickam AFB, Hawaii, feeds a baby.*

Nightingale House: Home Away from Home

Maj. Ralph Charlip, MSC
Maj. David Estill
Capt. Gretchen Lizza

If you have a critically ill family member, then Wright-Patterson Air Force Base's 2750th Air Base Wing and the USAF Medical Center Wright-Patterson have a unique support program for you: it's called the Nightingale House. Patterned after the well-known Ronald McDonald House concept, the Nightingale House is the first of its kind in the Department of Defense.

The house, formerly a military family housing unit, was designated by the base commander as a transient billeting facility. Like other transient quarters, it is operated by the base services squadron. The medical center coordinates reservations for the house, and a private organization called the Nightingale House Support Association provides volunteers to staff the house and services not offered by the Air Force.

Using the base commander's Quality of Life funds, the civil engineering squadron made minor interior modifications required by fire codes to upgrade the house from a private residence to transient quarters. The quarters are located next to the medical center's parking lot. A rear walkway from the house to the parking lot provides ready access to-and-from the medical center for guests.

The Nightingale House, at Wright-Patterson AFB, Ohio, provides shelter to family members of patients.

The Nightingale House Support Association was formed specifically to provide a house manager and hosts and hostesses for the house. The Association also solicits in-kind donations of items such as toys to make the house more like a home. With more than 100 people volunteering in less than two months, the association is a key partner in the house's success.

Daily maid service is provided to common areas like the two kitchens and four bathrooms. In addition, maid service is provided weekly in each room consisting of normal cleaning and linen exchange. Each guest is asked to keep his or her room clean between weekly maid service.

The concept of a Nightingale House stems from patient experiences with critically ill children and the lack of family-oriented housing specifically designed for medical center patient families.The 2750th ABW Family Action and Information Board supported the idea, and with the approval of the base commander, Col. Dennis Tewell, the house was operational in less than eight months.

The house's name was selected to depict the close relationship between the medical center, the Wright-Patterson AFB community, the humanitarian mission of the house and the C-9 Nightingale that provides airlift for patients and their families.

The Nightingale House success story is an example of the concern for the Air Force family and the dedication to service by the many people of the Medical Service, base agencies, and private enterprise.

Maj. Ralph Charlip is the director, patient administration, at the USAF Medical Center Wright-Patterson, Wright-Patterson AFB, Ohio. Maj. David Estill is the commander, 2750th Services Squadron, Wright-Patterson AFB. Capt. Gretchen Lizza is the intelligent systems integration manager, Armstrong Aerospace Medical Research Laboratory, also at Wright-Patterson.

Col. (Dr.) Thomas M. McNish

Nancy Ragan

(Editor's note: This article is reprinted with permission from "Air Force Recruiter")

Like the children's chant of "doctor, lawyer, Indian chief," Col. (Dr.) Thomas M. McNish has had a very interesting and varied Air Force career. Only his goes like this: pilot, POW, physician chief—chief consultant to the Air Force surgeon general for flight medicine, that is.

Dr. McNish, currently assigned to Bolling AFB in Washington, D.C., says he got to where he's at now by a very circuitous route—one that included an unplanned stopover in a North Vietnamese prison camp.

He began his career at the Air Force Academy in Colorado Springs, Colo. After graduating from the Academy in 1964, the then second lieutenant entered undergraduate pilot training.

Immediately after earning his silver wings and checking out in the F-105, Lieutenant McNish headed for Thailand. After 45 combat missions over North Vietnam, his plane was shot down and he was taken prisoner and held captive for six and one-half years.

Upon his return from Vietnam he returned to school to pursue his medical degree at Emory University School of Medicine in Atlanta.

In his current position Dr. McNish works with the Air Force Surgeon General regarding flight medicine topics to ensure care of fliers and their families.

"It's part of my job to develop the standards and guidelines to make sure the pilots are capable of flying aircraft. It's something that I couldn't do in any other type of medical practice anywhere in the world. No amount of money can buy that."

Before moving to his current job, Dr. McNish was assigned to Holloman Air Force Base, N.M. There he was pilot, physician, flight surgeon and hospital commander. "As hospital commander, I practiced clinical medicine—both family practice and flight medicine." Dr. McNish said, "Where else but the Air Force would you get to do those kinds of things?"

He says flight surgeons work closely with the squadrons they're assigned to. "The best thing about that kind of position is that you get to know your patients," he said. "I worked with the same people most of the time. And because I knew most of my

patients, I was able to practice better medicine. It's very much like a family practice on the outside."

Dr. McNish was sent to Holloman because of his background. "Holloman has the only training centrifuge for G-stress endurance in fighter-type aircraft, he said. "As a pilot, and since all of my specialized study and research has been in the field of G-induced loss of consciousness or tolerance of long-term exposure to 'G" forces, I could work with pilots and understand their problems."

The Air Force has given him "the unique opportunity to fly high-performance aircraft and practice medicine," he said. "And now I'm working the programs that keep people fit to fly." He added that today's fighters produce high-gravitational forces that challenge the physical and mental abilities of pilots.

He said the attention the Air Force pays to quality assurance results in good care for our people. "That's something we can really be proud of."

One reason that he believes Air Force medicine is so much better is because of the Health Professions Scholarship Program. "Our scholarships are so highly sought after that we can afford to be very selective. Granted, people who make high grades don't necessarily became good physicians, but I think it's an excellent starting block."

He has traveled an unusual route to get to where he is today, and not every Air Force doctor can become a flight surgeon. "But," he said, "if you choose Air Force medicine, you're going to learn a lot. You're going to work with professionals—and you'll be able to practice quality medicine. Whether you choose to do it for a short time or as a career, we have opportunities that exist nowhere else in the world."

Nancy Ragan is a writer with Headquarters, Air Force Recruiting Service, Randolph AFB, Texas.

Medical Service Awards

AHA Federal Health Care Executive Special Achievement Award

Lt. Col. Robert E. Shields, MSC, received the American Hospital Association Federal Health Care Executive Special Achievement Award for 1990 during the association's annual convention in Washington, D.C. Colonel Shields currently serves as commander of the 66th Electronic Combat Wing Clinic, Sembach Air Base, West Germany. At Sembach, he has led the clinic to an impressive record of performance in health service management, NATO tactical evaluation and USAFE unit effectiveness inspections. Colonel Shields' selection was based on his sustained record of exceptional leadership, superb accomplishments, and outstanding contributions to the delivery of health care services during a distinguished 20-year Air Force career.

Malcolm Grow Award: Flight Surgeon of the Year

Maj. (Dr.) Kenneth L. Cox was presented the Malcolm Grow Award as the U.S. Air Force Flight Surgeon of the Year by the Society of U.S. Air Force Flight Surgeons at their annual meeting. Major Cox is the chief of aeromedical services, 52nd Tactical Fighter Clinic, Spangdahlem Air Base, West Germany. He is responsible for a significant increase in health promotion activities and improved access to medical care for both fliers and family members. His special projects include writing a Provider Readiness Handbook and computerizing his medical office to have ready access to patient education material. Major Cox wins the award for making the greatest contribution to the effectiveness of a flying organization during the past year.

Col. Cleveland L. Parker Award

SMSgt. William B. Ergenbright Jr. is the winner of the Col. Cleveland L. Parker Award. This award recognizes the accomplishments of the most outstanding enlisted person in the entire environmental health career field. Sergeant Ergenbright is the superintendent, environmental health services, assigned to the 31st Medical Group, Homestead AFB, Fla. He led his section to the highest 1989 Health Services Management Inspection rating in Tactical Air Command by scoring excellent in all 17 environmental health services areas, and was the 31st Medical Group's Senior NCO of the Year for 1989. Sergeant Ergenbright was particularly honored to receive the award, since he had worked for Colonel Parker and highly respected him.

Information for Authors

The focus of the "*Medical Service Digest*" is on the people, programs and activities of the Air Force Medical Service. All members of the Medical Service are encouraged to submit interesting, informative articles that would appeal to a broad spectrum of medical officers, enlisted members, and civilian employees.

Some Tips for Publication

With the approval of the surgeon general and advice of the editor, articles are selected for publication by the "*Medical Service Digest*" editorial advisory board. Members of the board are listed on page 2 of all "*Digest*" issues and are available to discuss story ideas at any time.

Some patterns have emerged from the recent editorial decisions of the board:

Focus on Air Force people, programs and activities. Articles that paraphrase a regulation, summarize a directive, or restate a policy letter are almost always rejected. On the other hand, articles that illustrate how medical people have accomplished a mission, met a challenge, or responded to a crisis are always in demand.

Strive for broad readership. The Medical Service is made up of many educated, energetic, intelligent people, and the "*Digest*" needs to reach them all. Avoid writing articles that only your professional peers would understand.

Use simple English. Overuse of acronyms and technical jargon has doomed many articles to rejection. A good rule of thumb is to strive for content a high school student could understand. Active voice is always better than passive voice.

Submit photographs, illustrations, and diagrams. A picture is indeed "worth a thousand words." Use them to grab your readers' attention and to emphasize your topic.

Timeliness counts. Except for historical features, the editorial advisory board always selects topics of current interest over ones that are stale.

Avoid duplication. A quick review of recent issues of the "*Digest*" can help in this regard. Unless you have a totally new slant, topics published within the past year are poor candidates for publication.

Be factual. The author is responsible for ensuring that all material is complete, accurate and current. Articles with more opinion than fact are almost always rejected.

Prepare for some editing. Almost all submissions are edited before publication. Some changes are made to keep within the space limitations of the "*Digest*," while others are made simply to improve the final product. Accept editorial suggestions positively.

Enjoy the writing experience. Having an article published in the "*Digest*" represents a significant professional and personal accomplishment. An enthusiastic, positive approach is evident to readers and to members of the editorial advisory board.

Format for Submissions

In the interest of consistency, submission of articles for publication should meet the following specifications:

- Submit an original and two copies of double-spaced text, with one-inch margins on all sides.
- Number each page except the first page.
- Use subheadings whenever possible to organize the article and aid reader understanding.
- Number references consecutively in the order in which they are first mentioned in the text. Identify references in the text, tables, and legends by arabic numerals (in parentheses).
- For photographs, black and white glossies, either 5" x 7" or 8" x 10" work best. Send original, camera-ready illustrations and diagrams because copies do not always reproduce very well.
- Include name, rank, address, DNS number and duty title of all authors. If there is more than one author, please indicate if one is the primary author—he or she would be listed first on the byline.

References

Use the style of the examples below that are based on the formats used by the U.S. National Library of Medicine in "*Index Medicus*." Titles of journals are abbreviated according to the "*Index Medicus*" style.

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1. Standard Journal Article (List all authors when six or less; when seven or more, use only the first three and add et al.)
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6. Newspaper Article
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7. Magazine Article
   Budish AD. Avoiding the Medicaid trap: How to protect yourself from the staggering costs of nursing home care. The Retired Officer Magazine 1990 Sep, Vol XLVI, No 9:37-39.

Clearance Procedure

All articles require clearance before they can be published. Send your original and two copies to the "*Medical Service Digest*" through the following official channels: supervisor, facility/unit commander, base public affairs office, MAJCOM public affairs office and MAJCOM surgeon. The fully cleared article is then mailed to:

Editor, "*USAF Medical Service Digest*"
HQ USAF/SGI
Bolling AFB, DC 20332-6188

Additional information is available in AFR 190-1, Ch. 11, "Security and Policy Review."

Other Questions?

Members of the editorial advisory board and the "*Digest*" editor can help you with story ideas. In addition, the editor will be glad to answer any questions relating to the policies and procedures of the "*Digest.*" Please feel free to contact them at any time.

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Capt. Scott M. Nichelson, 66th Electronic Combat Wing Clinic, Sembach AB, West Germany

American Board of Internal Medicine
Maj. Woo K. Song, Air Force Institute of Technology, Wright-Patterson AFB, OH
Capt. Scott T. Anderson, Air Force Institute of Technology, Wright-Patterson AFB, OH

American Board of Oral and Maxillofacial Surgery
Lt. Col. David P. Kretzschmar, 832nd Medical Group, Luke AFB, AZ

American Board of Orthodontics
Lt. Col. Leighton W. Wood, Wilford Hall USAF Medical Center, Lackland AFB, TX

American Board of Orthopaedic Surgery
Lt. Col. Bernard F. Hearon, Air Force Institute of Technology, Wright-Patterson AFB, OH
Maj. Fabie F. Fiore, 56th Medical Group, MacDill AFB, FL

American Board of Pediatrics
Capt. Gary D. Crouch, Air Force Institute of Technology, Wright-Patterson AFB, OH
Capt. William A. Gibson, USAF Hospital Robins, Robins AFB, GA

American Board of Periodontology
Lt. Col. Walter C. Kirk, 857th Strategic Hospital, Minot AFB, ND
Lt. Col. Warren H. Marttala, USAF Clinic McChord, McChord AFB, WA
Lt. Col. Lawrence C. Parrish, 832nd Medical Group, Juke AFB, AZ
Maj. Chris Collier, 2nd Strategic Hospital, Barksdale AFB, LA
Maj. Kathleen A. Lindell, USAF Medical Center Kessler, Kessler AFB, MS

American Board of Prosthodontics
Lt. Col. Stephen J. Haney, USAF Regional Hospital Sheppard, Sheppard AFB, TX
Lt. Col. Robert R. Hawley, USAF Clinic Randolph, Randolph AFB, TX
Lt. Col. Michael S. Jacobs, USAF Regional Hospital Sheppard, Sheppard AFB, TX
Lt. Col. John A. Levon, Wilford Hall USAF Medical Center, Lackland AFB, TX
Lt. Col. Michael T. Potter, USAF Medical Center Kessler, Keesler AFB, MS
Maj. George M. Horsley, USAF Medical Center Scott, Scott AFB, IL

American Board of Radiology
Maj. William R. Protzer, Air Force Institute of Technology, Wright-Patterson AFB, OH
Maj. Mary L. Green, University of California at San Francisco (Pediatric Radiology)

American Board of Surgery
Maj. David J. Friedman, 1st Strategic Hospital, Vandenberg AFB, CA
Maj. Henry W. Cheu, Indiana University Medical Center, Indianapolis, IN
Maj. Jeffrey J. Pelton, Air Force Institute of Technology, Wright-Patterson AFB, OH

American Nurses' Association (Advanced Nursing Administration)
Col. Sue E. Turner, Headquarters U.S. Air Forces Europe, Ramstein AB, West Germany

American Osteopathic Board of General Practice
Maj. Walter Grady, Air Force Institute of Technology, Wright-Patterson AFB, OH

Federal Services Board of General Dentistry
Lt. Col. Larry D. Anderson, Wilford Hall USAF Medical Center, Lackland AFB, TX
Lt. Col. Larry J. Casey, 50th Tactical Fighter Wing Hospital, Hahn AB, West Germany
Lt. Col. Benjamin P. Graham, USAF Hospital Lajes, Lajes Field, Azores
Lt. Col. William R. Langenderfer, USAF Medical Center, Wright-Patterson AFB, OH
Lt. Col. Bradner J. Lawrence, 7276th Air Base Group Hospital, Incirlik AB, Turkey
Maj. Douglas A. Clarke, 1st Medical Group, Langley AFB, VA
Maj. Robert L. Eckles, 4th Medical Group, Seymour Johnson AFB, NC
Maj. William R. English, USAF Academy Hospital, USAF Academy, CO
Maj. Dennis J. Fasbinder, 836th Medical Group, Davis-Monthan AFB, AZ
Maj. Dennis N. Green, 52nd Tactical Fighter Wing Clinic, Spangdahlem AB, West Germany
Maj. James J. Kane, 857th Strategic Hospital, Minot AFB, ND
Maj. Deniel L. Leonard, 410th Strategic Hospital, K.I. Sawyer AFB, MI
Maj. Jesse T. McVay, 812th Strategic Hospital, Ellsworth AFB, SD
Maj. Thomas J. Plamondon, 842nd Strategic Hospital, Grand Forks AFB, ND
Maj. Ronald C. Pratt, USAF Clinic McChord, McChord AFB, WA
Maj. Ridley O. Ross, 10th Tactical Fighter Wing Clinic, RAF Upwood, United Kingdom
Maj. Joseph A. Snyder, 840th Strategic Clinic, Malmstrom AFB, MT
Maj. Derrick K. Wilcher, USAF Regional Hospital Elmendorf, Elmendorf AFB, AK

International Certification Commission for Clinical Engineering and Biomedical Technology
Capt. Dennis R. Minsent, Air Force Medical Logistics Office, Ft Detrick, MD

Pediatric Dentistry Specialty Board
Maj. Jeffrey H. Camm, Wilford Hall USAF Medical Center, Lackland AFB, TX

In Memoriam

We regret to announce the death of **Maj. Gen. (Dr.) Marvin Edward Kennebeck, USAF, Retired,** on June 18, 1990. General Kennebeck was assistant for dental services, Office of the Air Force Surgeon General from June 1952 until his retirement in January 1958.

General Kennebeck was born in Carroll, Iowa, on Oct. 19, 1901, where he attended local schools and graduated from high school in 1919. After attaining a Doctor of Dental Surgery degree from the University of Iowa in June 1924, he was commissioned a first lieutenant in the Dental Officers Reserve Corps. He entered active duty in September of that year as an assistant dental surgeon at Walter Reed General Hospital in Washington, D.C. After graduating in 1927 from the Medical Field Service School at Carlisle Barracks, Pa., he spent three years as assistant dental surgeon at Schofield Barracks, Hawaii. In June 1930, he went to New Jersey to become the dental surgeon at Fort Hancock. Five years later he became assistant dental surgeon at Randolph Field, Texas, where he served until 1939, when he was appointed post dental surgeon at Fort Mills, Corregidor, Philippine Islands.

During World War II, General Kennebeck had four stateside assignments as a dental surgeon, including Fort Bragg, N.C.,; Kelly Field, Texas; the Aviation Cadet Center in San Antonio, Texas; and Randolph Field, Texas.

After a stint as dental surgeon for the Air Training Command in 1946, he was appointed dental surgeon for the Indoctrination Division of Air Training Command at Lackland AFB, San Antonio, Texas, in November 1947, where he remained for two years. After transferring to the Air Force in July 1949, the general served a three-year assignment as air dental surgeon of the U.S. Air Force in Europe. In 1952, he returned to the states to the Office of the Air Force Surgeon General in Washington, D.C., initially as deputy assistant for dental services, and then as assistant for dental services.

During his tenure as assistant for dental services, General Kennebeck pioneered water fluoridation at Air Force bases, initiated the Air Force Preventive Dentistry Program, and introduced the Panoramic Dental X-ray machine as well as the use of chrome cobalt alloy to replace gold in dental work. He also expanded dental officer and postgraduate training, which helped to improve dental officer morale and retention among Air Force dentists.

After his retirement in January 1958, the general taught for 13 years at the University of Texas Health Science Center Dental School in Houston.

General Kennebeck was past president of the Armed Forces Commission of the Federation Dentaire Internationale and past vice-president of the American Dental Association. He was a fellow of the American College of Dentists, the International College of Dentists and an honorary member of the Iowa State Dental Society. Upon his retirement from the Air Force, he was awarded the Legion of Merit.

He is survived by one son, Marvin E. Kennebeck Jr., and five grandchildren.